February 24, 1998

Dear State Official:

This is one in a series of letters to States providing guidance on the new Children's Health Insurance Program (CHIP), which was enacted as part of the Balanced Budget Act of 1997 (BBA). This letter provides guidance to States on consultation with Indian Tribes and organizations and on using CHIP funds to benefit Indian children.

Consultation with Indian Tribes and Organizations

The President has directed all Federal Departments to engage in meaningful consultation with Federally recognized American Indian and Alaska Native (AI/AN) Tribes in order to ensure that the rights of these sovereign Tribal governments are fully respected. In addition to consulting with Federally-recognized Tribes, the Department encourages consultation with other Indian Tribes and organizations before taking actions that affect these governments and/or the Indian people residing within a State. Such consultation should be conducted in a meaningful manner. The Department of Health and Human Services uses this definition of meaningful consultation:

> Consultation is an enhanced form of communication which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties which leads to a mutual understanding and comprehension. Consultation is integral to a deliberative process which results in effective collaboration and informed decision making.

We are requesting that the State official responsible for CHIP consult with Federally recognized Tribes and other Indian Tribes and organizations in the State (such as regional Indian health boards, urban Indian health organizations, non-Federally recognized Tribes, and units of the Indian Health Service) on development and implementation of the CHIP State Plan.

This consultation process should be used in addition to the general public involvement process the State uses for CHIP. Prior to consultation, the State and Indian participants should establish a framework for the consultation process, determine the issues to be discussed, and decide how timely feedback will be provided to the Indian participants. (See Attachment for recommended consultation process and key issues).

Using CHIP Funds to Benefit Indian Children

As indicated in the attachment, American Indian/Alaska Native (AI/AN) children are more likely to experience many serious health conditions and have significantly less access to affordable health insurance and health care than other Americans. Under the law establishing the new program, Indian children are eligible for CHIP on the same basis as other children in the State in which they reside, regardless of whether or not they may be eligible for or served by IHS-funded care. (See attached question and answer.) In addition, the law specifically requires that each State describe in its CHIP State plan the procedures to be used to ensure the provision of child health assistance to targeted low-income AI/AN children in the State. Given the compelling health care needs of Indian children and these provisions, the Department encourages States to implement the CHIP program, in consultation with Tribes and Indian organizations, in a creative and flexible manner to allow Indian children to benefit from Title XXI to the maximum extent possible under the law.

To facilitate enrollment in regular Medicaid or CHIP, States may target outreach to reservation, urban, and other communities with high concentrations of low-income Indian people. States may use Title XXI's limited administrative funds in these communities for outreach to families with children likely to be eligible for benefits under Title XXI or other public or private health programs, to inform these families of the State program, and to assist them in enrolling their children when appropriate. Given the large numbers of low-income uninsured children in Indian communities, targeting outreach to such communities is part of an effective outreach strategy.

States may also use Title XXI administrative funds to target low-income AI/AN communities for health services initiatives to improve the health of low-income children. In addition to Title XXI services, such health services initiatives could include health education, school health programs, and direct services (such as newborn screenings). These activities can assist Indian children, both those eligible and ineligible for Title XXI, if they promote the public's health in a targeted county, community, or school in which all children are equally eligible to benefit from the initiative. Please note that expenditures for health initiatives, outreach, administrative costs, and other child health assistance are subject to the 10 percent limit specified in section 2105(c)(2)(A) of the law.

We hope that the outreach efforts, health services initiatives, and other aspects of the CHIP program, developed in consultation with Tribes and Indian organizations, will help your State achieve the goal of providing access to health care for all vulnerable children. A list of contact people for American Indian and Alaska Native issues is included on the attachment. They, along with HCFA and HRSA Regional Office CHIP staff are available to assist you with the consultation process and with efforts to use CHIP funding to assist American Indian and Alaska Native children. Thank you for your continued efforts on this important program.

Sincerely,

Sally K. Richardson, Director Claude Earl Fox, M.D., M.P.
Center for Medicaid and State Operations
Acting Administrator Health Care Financing Administration
Health Resources and Services Administration

Attachment

cc:
HHS Regional Directors

HCFA Regional Offices
PHS Regional Offices
Ms. Lee Partridge, American Public Welfare Association
Ms. Jennifer Baxendell, National Governors' Association
Ms. Joy Wilson, National Conference of State Legislatures
Ms. Cheryl Beversdorf, Association of State and Territorial Health Officials
Ms. Mary Beth Senkewicz, National Association of Insurance Commissioners

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ATTACHMENT

INDIAN CHILDREN AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

HEALTH CARE NEEDS OF INDIAN CHILDREN

The health care needs of Indian children are compelling. The Indian population has a greater proportion of children (33 percent younger than age 15, compared with 22 percent for the U.S. population of all races) and a higher birth rate (26.6 live births per 1,000 population, compared with 15.9 per 1,000 for U. S. all races). In recent years, both maternal and infant mortality rates for Indian people have been reduced to levels comparable to those of the U.S. population generally. However, teen pregnancy is much higher, with 45 percent of Indian mothers under age 20 at the birth of their first child, compared with 24 percent of U.S. mothers of all races. In addition, a much greater proportion of Indian people continue to live below the Federal poverty level (1990 Census shows 31.6 percent of Indians residing in the 35 States with Indian reservations had incomes below the Federal poverty level -- a rate 2.4 times the comparable rate for Americans of all races). Poverty, geographic isolation, and substance abuse contribute to the much higher Indian child mortality rates due to causes such as accidents, homicide, suicide, SIDS, viral hepatitis, meningitis, pneumonia, and influenza, compared with other American children. Indian children have high rates of hospitalization and ambulatory medical visits for conditions such as respiratory system diseases, infectious and parasitic diseases, digestive system diseases, injuries and poisonings.

Very few Indian people have access to or can afford private health insurance. Many living on reservations depend upon IHS-funded health care. IHS per capita spending is only one third the amount spent on health care by the average American. IHS direct care, and IHS-funded Tribal and urban Indian health programs provide mostly primary care services. IHS funds used to pay other health care providers for specialty care are extremely limited, estimated to meet only about 60 percent of the need for such services.

Approximately half or more of Indian people live off reservations in other rural and urban areas and often lack access to affordable, culturally appropriate care. IHS is able to fund 33 urban Indian programs for a total of only about $25 million. Many of these urban programs are only able to provide limited behavioral health services and information and referral rather than comprehensive services, leaving many unmet needs. Thus, CHIP presents a unique opportunity to maximize the potential for Federal and State funds to help fill some of the large gaps in health care for uninsured, low-income Indian children by expanding the provision of child health assistance in an effective and efficient manner.

ELIGIBILITY OF INDIAN CHILDREN FOR CHIP

In the fourth set of Title XXI questions and answers, issued November 26, 1997, by the Health Care Financing Administration, we answered a question regarding the eligibility of Indian children for CHIP as follows:

Question: Are American Indian/Alaska Native children eligible for the Children's Health Insurance Program?

Answer: Yes, American Indian/Alaska Native children are eligible for CHIP on the same basis as other children in their State. Children, both Indian and non-Indian, may be eligible for CHIP if they meet State eligibility standards based on the definition of "targeted low-income child" in Section 2110(b) of the law. The eligibility of Indian children for CHIP is not affected by the fact that they may also be eligible for or are recipients of health care services funded by the Indian Health Service (IHS). Section 2105(c) (6)(B) of the law

specifically exempts programs operated or financed by IHS from the requirement to prevent duplication between CHIP and other federally operated or financed health programs. Finally, Section 2102(b)(3)(D) of the law requires each State to describe, in its CHIP State plan, the procedures to be used to ensure the provision of child health assistance to targeted low-income children in the State who are American Indians or Alaska Natives.

CONSULTATION PROCESS AND KEY ISSUES

The consultation process should address the conceptual development of the CHIP plan, eligibility standards and methodology, outreach and coordination, and procedures to be used to ensure the provision of child health assistance to targeted low-income children in the State who are Indians. Key issues for consultation include: geographic areas to be served; income and resource standards; coordination of coverage with IHS-funded care; participation and reimbursement of IHS/Tribal/urban Indian health care providers; the role of traditional Indian healing; premiums and cost sharing; outreach, eligibility, and referral; criteria for deciding whether to provide Medicaid and/or private health insurance coverage; categories of additional services and other benefits; measurable goals related to health status and health demographics for Indian children; and criteria for and design of health services initiatives.

CONTACTS FOR AMERICAN INDIAN/ALASKA NATIVE ISSUES

Health Care Financing Administration

Region 1:
Craig Schneider 617-565-4483
(Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont)

Region 2:
Carol Conciatori 212-264-3889

(New Jersey, New York, Puerto Rico, Virgin Islands)

Region 3:
Carol Messick 215-596-0580
(Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia)

Region 4:
Carol Langford 404-562-7412
(Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee)

Region 5:
Lucille Rinaldo 312-353-9842
(Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin)

Region 6:
E. Dorsey Sadongei 214-767-3570 (Arkansas, Louisiana, New Mexico, Oklahoma, Texas)

Region 7:
Cheryl Chapman 816-426-2011
(Iowa, Kansas, Missouri, Nebraska)

Region 8:
Peggye Wilkerson 303-844-6336, X345, Jean Fleury 303-844-6336, X346
(Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming)

Region 9:
Ron Reepen 415-744-3601, Sue Castleberry 415-744-3597
(Arizona, California, Hawaii, Nevada, Pacific Islands)

Region 10: Dennis Sexton 206-615-2398
(Alaska, Idaho, Oregon, Washington)

Washington, DC: Lloyd Bishop 202-690-8501,

Inter-Governmental and Tribal Affairs Group

Health Resources and Services Administration Rockville, MD

June Horner 301-443-2964

Indian Health Service Rockville, MD

Michael D. Mahsetky 301-443-7261,

William C. Vanderwagen, M.D. 301-443-3024

Health and Human Services/Intergovernmental Affairs Washington, DC